North Carolina Central Cancer Registry

Department of Health and Human Services
Division of Public Health
State Center for Health Statistics

Cancer Incidence Reporting Form

Urology

PATIENT INFORMATION

Patient's Name: Last First Middle

ADDRESS AT TIME OF DIAGNOSIS: Street	SSN:	Sex: ☐ Male ☐ Female
City	Date of Birth: MM/DD/YY	Race ☐ White ☐ Black ☐ American Indian ☐ Other (please specify)_____
State	Primary Payer(s) at DX:	
Zip	Patient's County of Residence at DX:	If Patient is of Hispanic Origin, Please List Type (Mexican, Puerto Rican, Cuban, etc.) _____

CANCER DIAGNOSIS

Date of Diagnosis: MM/DD/YY	Primary Site:	Laterality: ☐ Right ☐ Left ☐ Midline ☐ N/A	Vital Status: ☐ Alive ☐ Dead

Pathology/Laboratory Findings (please attach copies of initial and final path reports):
Values: PSA _____ Gleason's Score _____+_____=_____ AFP _____ LDH _____ hCG _____

Surgical Treatment (please attach copies of operative notes for biopsy and/or definitive treatment, to include any lymph node biopsy):

TURP	Prostatectomy	Orchiectomy	TURB	Cystectomy	Nephrectomy
Date:_____	Date:_____	Date:_____	Date:_____	Date:_____	Date:_____

Other: (Please Specify) _____ Date: _____

Other Treatment Therapy:

Radiation	Hormone	Chemo	Immuno	Hematologic	Endocrine
Date:_____	Date:_____	Date:_____	Date:_____	Date:_____	Date:_____
Type:_____	Type:_____	Type:_____	Type:_____	Type:_____	Type:_____
Dose:_____	Dose:_____	Dose:_____	Dose:_____	Dose:_____	Dose:_____

Other: (Please Specify) _____Type:_____ Dose:_____ Date: _____

X-Ray/Scans Findings relevant to the diagnosis or treatment of this cancer (CXR, MRI, CT, PET, etc., please attach copies):

If patient was referred to another facility or doctor for treatment, please list name referred to:

If patient was referred from another facility for diagnosing and/or treatment, please list name of referring facility or doctor:

Does patient have a prior history of cancer? (Include cancer of any histology; please list site, histology and date of diagnosis if available, exclude basal cell carcinoma and squamous cell carcinoma of the skin):

Name of individual completing this form: _____

Date: _____

Please mail your completed form to the designated address below:
☐ NCCCR • 222 N. Dawson Street • Raleigh, NC 27603 • Phone # (919) 715-0650 • Fax # (919) 715-7294
☐ Venita Brannigan • NCCCR • 225 N. McDowell Street • Raleigh, NC 27603 • Phone # (910) 848-2462 • Fax # (910) 848-2510

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